

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011914 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/07/2012 |
| NAME OF PROVIDER OR SUPPLIER CROWN POINTE SENIOR LIVING COMMUNITY | | STREET ADDRESS, CITY, STATE, ZIP CODE 1034 CROWN POINTE BLVD GREENSBURG, IN 47240 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| R 000 | <p>INITIAL COMMENTS</p> <p>This visit was for State Residential Licensure Survey.</p> <p>Survey dates: February 6 and 7, 2012</p> <p>Facility number: 11914 Provider number: 11914 AIM number: N/A</p> <p>Survey team: Jill Ross, RN, TC Cheryl Fielden, RN Diana Sidell, RN Janie Faulkner, RN</p> <p>Census bed type: Residential: 28 Total: 28</p> <p>Census payor type: Other: 28 Total: 28</p> <p>Sample: 7</p> <p>Crown Point Senior Living Community was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey.</p> <p>Quality review completed 2/7/12 Cathy Emswiller RN</p> | R 000 | | |

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

2XIV11

If continuation sheet 1 of 1